United States General Accounting Office

GAO

Report to the Chairman, Committee on Finance, U.S. Senate

August 1993

MEDICAL MALPRACTICE

Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses

GAO/HRD-93-126

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-351013

August 11, 1993

The Honorable Daniel P. Moynihan
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

While the precise extent to which medical malpractice has contributed to the spiraling health care bill is unknown, the costs associated with it run into the billions of dollars. A number of health care bills have been introduced in the Congress to help control costs and improve access to health care. Several included proposals to reform the malpractice claims system. Some of these target malpractice reforms to the Medicare and Medicaid programs. Even though Medicare and Medicaid beneficiaries account for about 35 percent of the nation's health care costs, only limited information has been compiled on the frequency and outcomes of malpractice suits involving Medicare and Medicaid patients.

Because of the limitations of current information, you requested that we review Medicare and Medicaid patients' involvement in malpractice litigation.[1] As agreed with your office, we (1) reviewed the literature and existing data to compare the incidence and outcomes of malpractice litigation involving Medicare and Medicaid patients to that of the general population and (2) analyzed aggregate hospital data on malpractice losses for Medicare, Medicaid, and other hospital patients.

Results in Brief

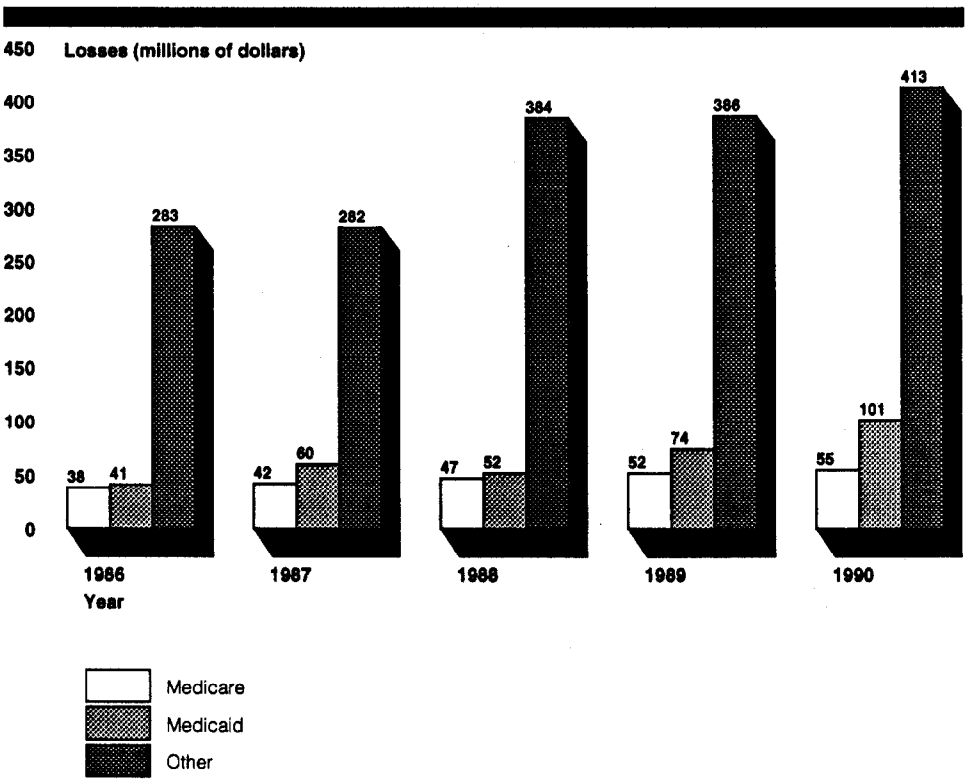
While the existing literature on the incidence and outcomes of malpractice litigation involving Medicare and Medicaid patients is limited, the completed studies provide useful data on malpractice during the last two decades and are consistent in their findings and conclusions. In general, studies of medical malpractice show that a small percentage of encounters with the health care system result in injury due to medical malpractice, and relatively few injuries due to medical malpractice result in claims. We and others have reported that malpractice claims take a long time to resolve and that less than one-half result in payment, either through settlement or judgment, to the plaintiff. Further, plaintiffs with small potential recoveries may have difficulty gaining access to the tort system because the cost to litigate such cases may exceed recoveries.

[1]Lloyd A. Bentsen, the former Chairman of the Senate Committee on Finance, also requested this study.

The experience of Medicare and Medicaid patients is consistent with these findings except that these patients are less likely than other patients to file malpractice claims. When they file claims, their awards or settlements are significantly lower than those for patients with other health insurance.

We found that hospital malpractice awards paid on behalf of Medicare and Medicaid patients account for a relatively small share of total hospital malpractice losses. From October 1985 through September 1990, Medicare and Medicaid patients received about one-fourth of the $2.3 billion of hospital malpractice awards, although they represent more than 45 percent of hospital patients. Malpractice losses for the 5-year period[2] are shown in figure 1.

Figure 1: Hospital Malpractice Losses by Type of Insurer, 1986 to 1990



[2]Information was obtained on malpractice losses for the 5-year period beginning October 1, 1985, and ending September 30, 1990—referred to as the 1986 to 1990 period in this report.

Medicare patients' percentage of hospital malpractice awards is significantly lower than their portion of hospital discharges and inpatient days. In 1990, Medicare patients accounted for about 32 percent of hospital discharges and 44 percent of hospital inpatient days but received only 9.6 percent of all hospital malpractice awards. Medicaid patients' percentage of malpractice losses is slightly higher than their discharge rate. They accounted for 14 percent of discharges and 13 percent of inpatient days but received 17.5 percent of all malpractice awards. In comparison, the percentage of malpractice losses paid to other patients with insurance is significantly higher than their hospital discharge rate. These patients accounted for 54 percent of discharges, 43 percent of inpatient days, and 72 percent of all malpractice losses.

Background

Medical malpractice is any deviation from the accepted standard of medical care that causes injury to a patient. An injured patient can file a lawsuit against a provider seeking compensation under tort law for economic losses, such as medical costs and lost wages, and noneconomic losses, such as pain and suffering.[3]

Both direct and indirect costs are associated with medical malpractice. The direct costs involve the cost of malpractice (medical liability) insurance, which health care providers purchase to cover losses arising from medical injuries for which they are responsible. In 1990, the cost of malpractice insurance accounted for about $7 billion—less than 1 percent of health care expenditures.

The indirect costs include the increased cost of health care resulting from the practice of defensive medicine, which occurs when physicians perform additional diagnostic tests and treatment procedures to support their decisions in case they are sued for malpractice. While the precise cost is difficult to determine, the American Medical Association estimated that physicians' defensive medicine may be increasing overall health care costs by about $15 billion a year.

Medicare is a federal health insurance program for people 65 or older and younger disabled persons. It helps pay medical costs for about 35 million beneficiaries under a two-part system: part A, which covers inpatient

[3]Negligence is the tort upon which most medical malpractice lawsuits are based. To recover damages in court for medical negligence, the plaintiff must show that the health care provider failed to meet an acceptable standard of care owed the patient and that the provider's negligence caused an injury to the patient resulting in damage or loss. The standard of care is established on a case-by-case basis through the testimony of expert witnesses.

hospital, home health, skilled nursing home, and hospice services; and part B, which covers physician, hospital outpatient, and other health services, such as diagnostic tests. In fiscal year 1992, Medicare benefit payments were about $120 billion.

Established in 1965 as title XIX of the Social Security Act, Medicaid is a federally aided, state-administered medical assistance program that served about 30 million low-income people in fiscal year 1992, with combined federal and state expenditures estimated at $119 billion. Within a broad federal framework, each state designs and administers its own Medicaid program and sets eligibility standards and coverage policies. The Health Care Financing Administration (HCFA), a part of the Department of Health and Human Services (HHS), administers the Medicare and Medicaid programs.

Scope and Methodology

In doing our work, we reviewed the literature on medical malpractice to identify studies done during the past two decades. We also analyzed data from Medicare's Hospital Cost Report Information System (HCRIS) on hospital malpractice losses from 1986 to 1990. This system, which contains information for more than 6,300 hospitals, is HCFA's national database for hospital costs.

Appendix I provides information on national and state studies relating to Medicare and Medicaid patients' involvement in malpractice litigation. Appendix II presents our analysis of HCRIS data relating to hospital malpractice losses. Appendix III provides additional information on our scope and methodology.

We are sending copies of this report to the Secretary of HHS; the Administrator of HCFA; interested congressional committees and subcommittees; the Director, Office of Management and Budget; and other interested parties. Copies will be made available to others upon request.

Please call me at (202) 512-7104 if you have any questions about the information discussed. Other major contributors to this report are listed in appendix IV.

Sincerely yours,

Leslie G. Aronovitz
Associate Director,
Health Financing Issues

Contents

Abbreviations

HCFA	Health Care Financing Administration
HCRIS	Hospital Cost Report Information System
HHS	Department of Health and Human Services
NAIC	National Association of Insurance Commissioners

Medicare and Medicaid Patients File Fewer Claims and Receive Smaller Awards Than Patients With Private Insurance

Medicare and Medicaid patients file fewer malpractice claims than patients with other insurance and at a rate below their representation in the general population. They receive significantly smaller malpractice awards and therefore may experience more difficulty in acquiring legal representation.

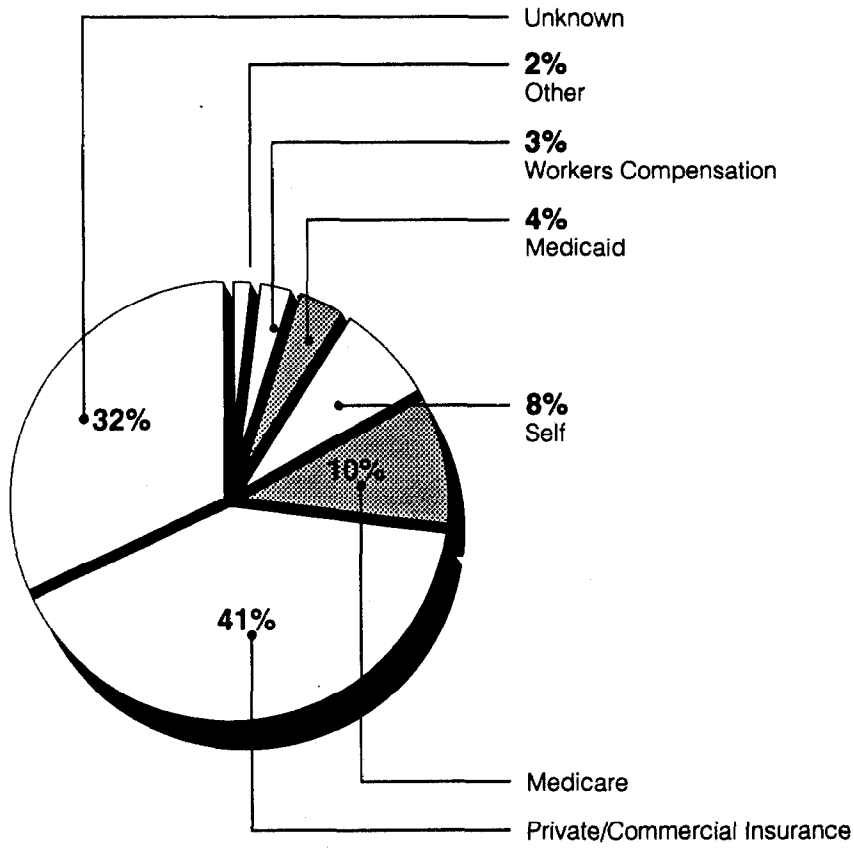
Review of Malpractice Claims Filed

A study that examined claims filed in Wisconsin in 1983 and 1984 found that elderly patients filed about 10 percent of the malpractice lawsuits and made up about 13 percent of the state's population.[1] Our closed claims study, which analyzed a nationally representative sample of malpractice claims closed in 1984, found that relatively few involved Medicare and Medicaid patients.[2] As shown in figure I.1, health care costs for about 41 percent of patients involved in medical malpractice claims were paid by private commercial insurers. About 10 percent and 4 percent of malpractice claims involved Medicare and Medicaid beneficiaries, respectively. In 1984, the elderly accounted for about one-third of the hospital admissions, while about 9 percent of the population were Medicaid beneficiaries.

[1]M. Sager and others, "Do the Elderly Sue Physicians?" Archives of Internal Medicine 150 (1990), pp. 1091-1093. This study analyzed 431 malpractice claims filed in 1983 and 1984. The study obtained information about these claims from the Wisconsin Patients Compensation Panel and attorneys. The study compared the frequency of litigation with the number of hospitalizations and inpatient days for those above and below the age of 65.

[2]Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 22, 1987). This review was undertaken as part of a comprehensive study of the medical malpractice phenomenon that looked at (1) the effect of medical malpractice on the quality, availability, and affordability of health care; (2) the equity of compensation for medical malpractice injuries; and (3) who should be responsible for taking corrective actions. We analyzed nationally representative data on malpractice claims closed in 1984. We developed the database used in this analysis by drawing a sample of 25 of the 102 insurers that wrote malpractice insurance in the United States in 1983. We then collected data on a sample of 1,706 of the 31,395 claims that these 25 insurers reported closing in 1984. These data were weighted to develop estimates on various characteristics of malpractice claims that were representative of all claims closed in 1984 by the 102 insurers in our universe. We estimated that these insurers closed 73,500 malpractice claims involving 103,300 health care providers. The study also provided data on the number of claims closed with indemnity payments, severity of injuries, characteristics of patients involved in the malpractice claims, patients' earnings and sources of payment for health care costs, and time required to resolve claims.

Figure I.1: Claims by Source of Payment for Health Care Costs



Studies of malpractice claims closed in three states also found that Medicaid patients file claims at a lower rate than their representation in the general population. Table I.1 presents the data from these studies.

Table I.1: Comparison of Medicaid Claims Filing Rate to Medicaid Population in Three States

State	Claims filed during—	Medicaid claims as a percentage of claims	Medicaid population as a percentage of state's population
Maryland[a]	1985-86	8.0	11
Michigan[b]	1985-87	6.0	10
Texas[c]	1986-87	3.5	12[d]

[a]M.G. Mussman and others, "Medical Malpractice Claims Filed by Medicaid and Non-Medicaid Recipients in Maryland," Journal of the American Medical Association, Vol. 265, No. 22 (1991), pp. 2992-2994. This study examined all malpractice claims filed during 1985 and 1986 to determine whether Medicaid beneficiaries are more likely than others to file malpractice suits. The study found that Marylanders who had ever been enrolled in Medicaid filed 132 of the 1,037 malpractice claims (12.7 percent)—a filing rate that was slightly higher than the proportion of Medicaid patients (11 percent) in Maryland's total population. However, when only those persons enrolled in Medicaid before and/or during the alleged malpractice incident were considered, the proportion of Medicaid patients filing claims dropped to 8 percent, or about 3 percent below the Medicaid enrollees' percentage of the state's population. The difference may represent patients who became eligible for Medicaid because of the losses arising from the injury.

[b]Medicaid Matters, State of Michigan, Department of Social Services, Vol. III, No. 2, (Feb. 1989). This study was performed by the Michigan Department of Licensing and Regulation which reviewed closed claim data for 1985 through 1987.

[c]Texas Medical Association, 1988 Professional Liability Survey (unpublished data). This study, performed in 1988 by the Texas Medical Association, surveyed a random sample of physicians in all medical specialties about their malpractice claims experience with Medicaid patients.

[d]Represents the number of patients seen by the surveyed physicians.

In addition to the above studies, a survey conducted in 1989 and 1990 of 187 Florida malpractice cases found that Medicaid patients accounted for 8 percent of birth injuries and 3 percent of injuries occurring in hospital emergency rooms. Further, about 22 percent of birth-injured claimants and 40 percent of emergency room claimants did not have health insurance at the time of injury. The researchers interpreted this lack of insurance as an indication of a larger social problem, namely, that a substantial portion of the U.S. population does not have insurance, and compensation from malpractice cases fills an unmet need. The researchers concluded that the data did not support the view that plaintiffs in medical malpractice cases were predominantly poor, on Medicaid, uneducated, or unhealthy. They also concluded that the threat of litigation did not appear to be a valid reason for physicians' refusal to accept such patients.[3]

[3]F.A. Sloan, "Winners & Losers: How Medical Malpractice Disputes Are Resolved," Journal of American Health Policy, (Sept./Oct. 1991), pp. 20-25. This survey examined 187 families in Florida who filed suits against physicians. The cases were closed at the time of the study and involved permanent injuries or death that occurred at birth or in an emergency room. The study provided data on the number of claimants with insurance, patterns of medical behavior and medical care before the injury, types of injuries, lawyers' role in tort cases, liability, and economic losses.

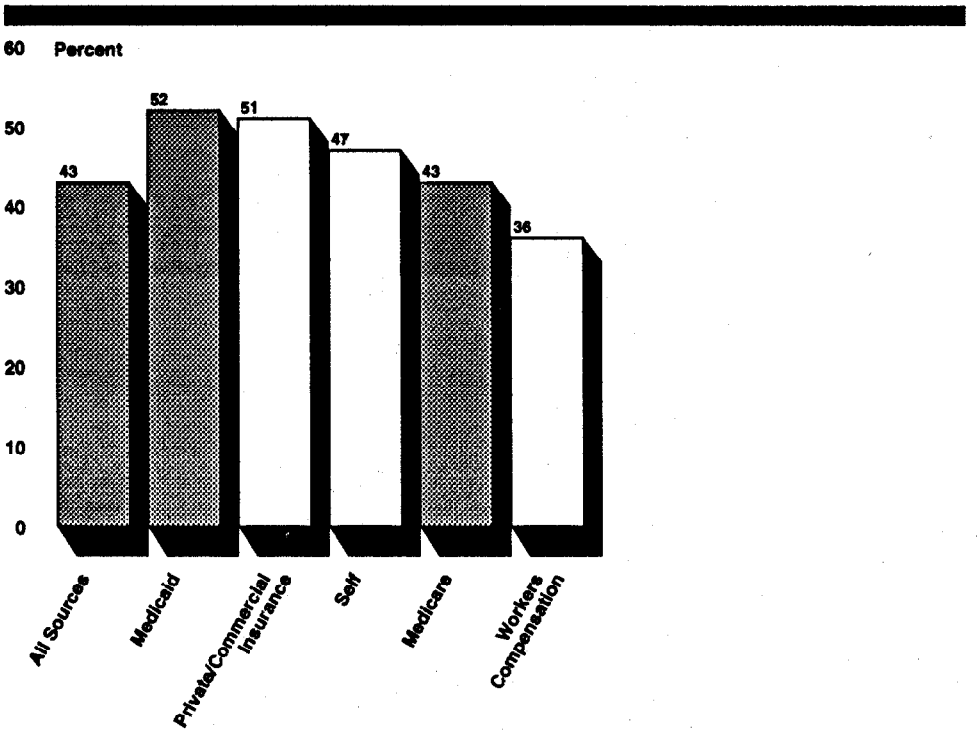
Claims Closed With Awards

A 1990 study by a Harvard group reported that about 1 percent of all New York hospital patients sustained a medical injury due to negligence.[4] The Harvard group estimated that 8 times as many patients suffered an injury from negligence as filed a malpractice claim, and 16 times as many patients suffered an injury from negligence as received compensation. The Harvard study also reported that, in many litigation cases, patient medical records contained no evidence of negligence or patient injuries.

Our study of claims closed in 1984 found that 43 percent of all malpractice claims were closed with indemnity payments. As shown in figure I.2, Medicare beneficiaries received payments in 43 percent of the cases while slightly more than 50 percent of the claims for Medicaid patients and patients with other health coverage were closed with indemnity payments.

[4]Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, the Report of the Harvard Medical Practice Study to the State of New York, 1990. This study evaluated the tort system handling of medical malpractice and considered the effects of alternative approaches to resolving claims. The study analyzed about 30,000 discharges that occurred in New York hospitals in 1984. Its purpose was to determine the (1) incidence of injuries resulting from medical interventions and the percentage of such events that resulted from fault or negligence of the physician or other provider; (2) percentage of negligent and non-negligent events that led to claims or suits; (3) cost of medical expenses, lost wages, and lost household production and compensation for such losses; and (4) degree to which litigation affected the incidence of injuries.

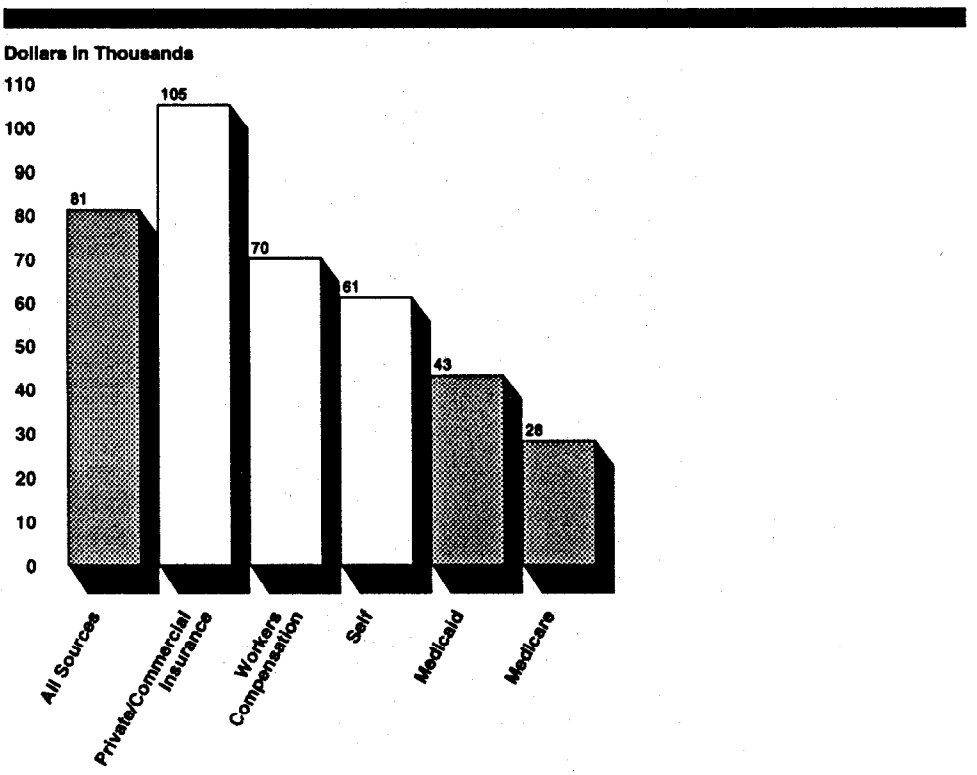
Figure I.2: Claims Closed With Payment by Source of Payment for Health Care Costs



When Medicare and Medicaid patients are successful claimants, they tend to receive smaller malpractice awards than patients with private/commercial insurance. Our study of claims closed in 1984 found that the average compensation for Medicare and Medicaid patients was $28,000 and $43,000, respectively, compared to about $105,000 for patients with private/commercial insurance.[5] Figure I.3 provides information on the average indemnity payments by the claimants' source of health care coverage.

[5]The source of payment of the patients' health care costs was unknown for about 23,800 claims or about 32 percent of the claims.

Figure I.3: Average Indemnity Payments by Source of Payment for Health Care Costs

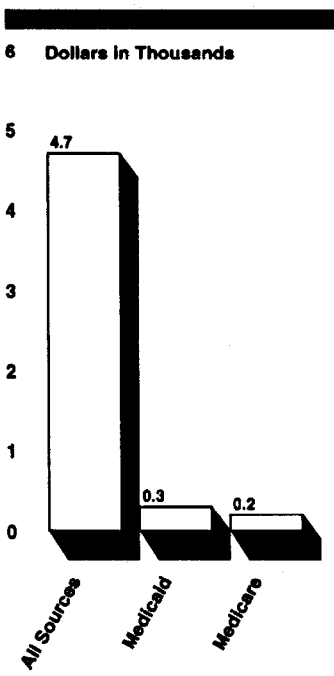


A National Association of Insurance Commissioners' study showed that, for closed claims with a payment, awards for people 65 and under were about two times greater than awards for people over 65.[6]

Lower awards for Medicare and Medicaid patients may be attributable to their employment status and income. Figure I.4 shows that, based on our 1984 closed claim data, Medicare and Medicaid patients had on average lost income, at the time of claim closure, that was significantly below the average lost income for other patients.

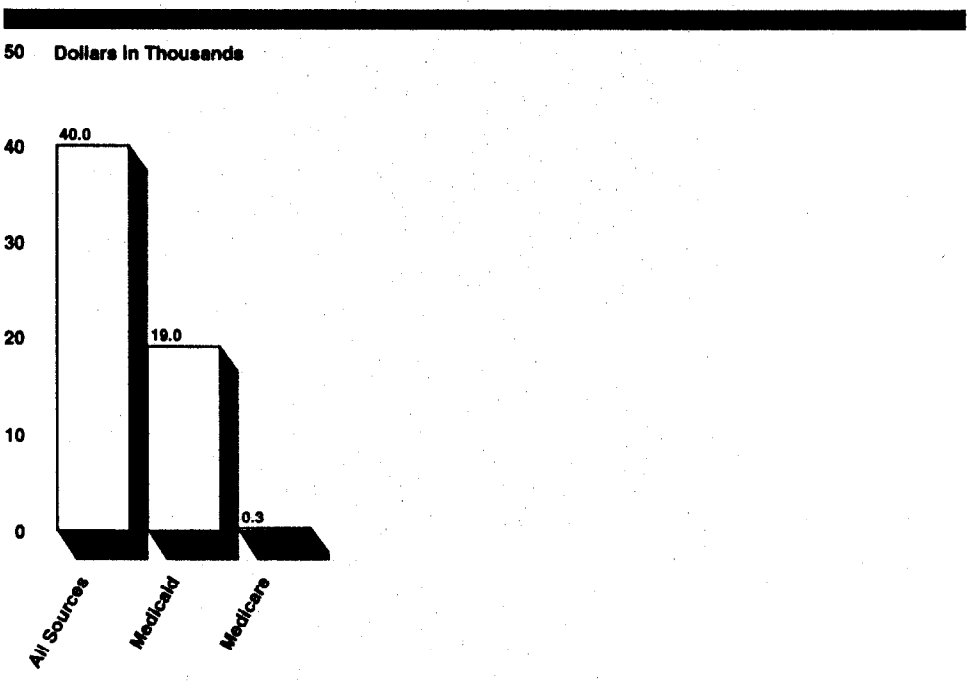
[6]The National Association of Insurance Commissioners (NAIC) published four books, titled NAIC Malpractice Claims, that were issued between December 1975 and May 1977. These publications were based on data from 25,000 claims closed between July 1, 1975, and June 30, 1976, by 54 insurers writing $1 million or more of malpractice insurance in any single year between 1970 and 1975. In October 1977, NAIC once again began collecting data on all claims closed since July 1, 1976. The physician-owned and hospital-owned malpractice insurance companies formed since 1975 participated in this effort. The analysis focused on developing programs aimed at preventing medical injuries, evaluating enacted and proposed legislation on medical malpractice issues, reviewing malpractice pricing methodology, and identifying hospital and professional loss prevention programs. A final compilation of data encompassed 71,782 closed claims and was issued in September 1980.

Figure I.4: Average Lost Income by Source of Payment for Health Care Costs



Further, as shown in figure I.5, the estimated future average lost earnings of Medicare patients were significantly below the estimated future average lost earnings of Medicaid and other patients.

Figure I.5: Average Estimated Future Lost Earnings by Source of Payment for Health Care Costs



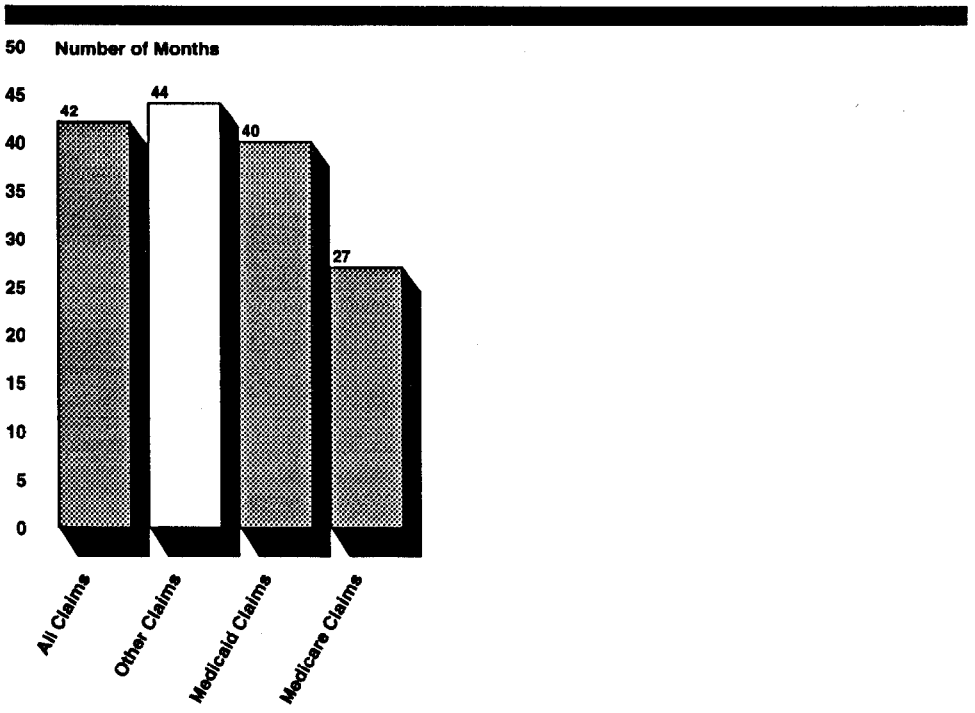
Because of their age, Medicare patients have fewer years of life remaining and, as a result, are likely to have lower total future medical expenses. Our prior work found that Medicare patients' future medical expenses averaged about $2,400, compared to average medical expenses of about $21,600 and $31,500, respectively, for Medicaid and patients with other insurance. In fact, because their economic losses tend to be lower, Medicare and Medicaid patients may experience more difficulty in gaining access to the litigation system. Patients with recoverable damages of less than $50,000 may find attorneys reluctant to represent them because the cost of bringing the case to trial may exceed the value of the claim.[7]

The malpractice claims process is also lengthy. Our study of claims closed in 1984 found that, from injury to claims closure, an average of about 42 months had elapsed—and claims involving more severe injuries took longer. Claims filed for Medicaid patients and patients with other health insurance coverage approximated the average. As shown in figure I.6,

[7]Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986). This report presented the perceptions of 37 national organizations representing medical, legal, insurance, and consumer interests. We developed information on the existence of medical malpractice problems, the need for federal involvement, and alternative approaches for resolving claims.

Medicare patients' claims took significantly less time to resolve but still averaged about 27 months.

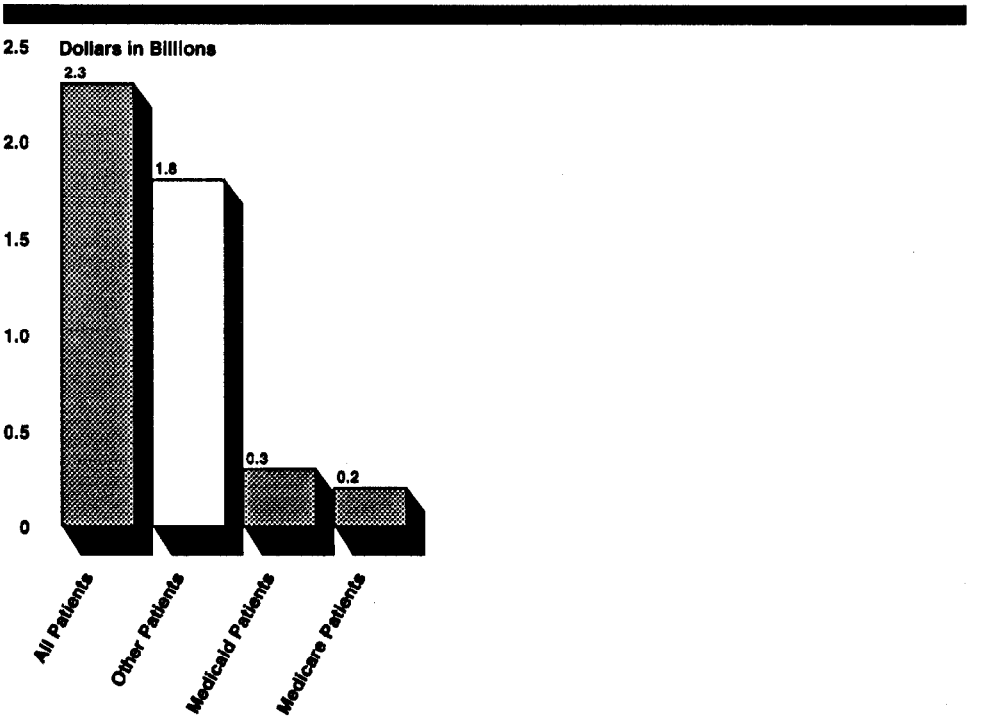
Figure I.6: Time to Resolve Malpractice Claims



About One-Fourth of Hospital Malpractice Losses Paid to Medicare and Medicaid Patients

In 1990, 1,178 hospitals, or 1 out of 5, reported malpractice losses to HCFA. Losses for these hospitals totaled $574 million, of which $156 million (27 percent) was paid for Medicare and Medicaid patients. From 1986 through 1990, 1,843 hospitals reported malpractice losses. As shown in figure II.1, losses for these hospitals totaled $2.3 billion, of which about $1.8 billion (74 percent) was paid for patients with private health care coverage.[1]

Figure II.1: Total Hospital Malpractice Losses by Type of Patients' Health Coverage, 1986 to 1990

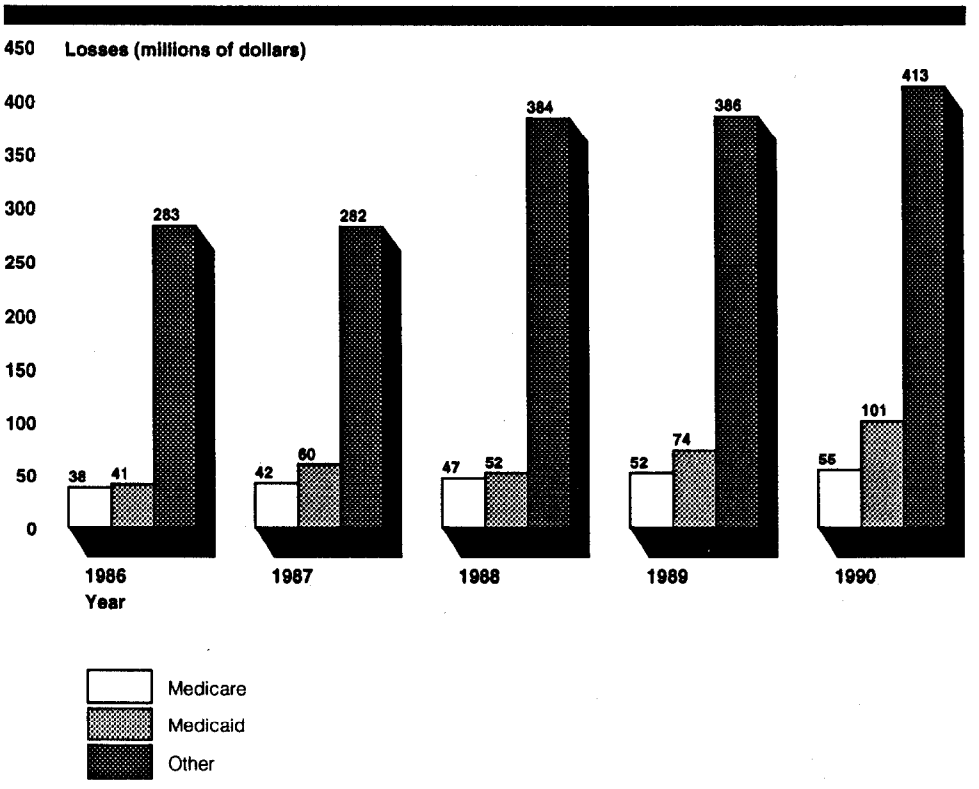


During this period the number of hospitals reporting malpractice losses declined, but malpractice losses grew at an average annual rate of about 9 percent. In 1986, hospital malpractice losses totaled $374 million or an average of $287,000 for hospitals with malpractice losses. In 1990, total losses increased to $574 million or $487,000 for hospitals with malpractice losses. The most notable increase was in the Medicaid program, where total hospital malpractice losses for program beneficiaries increased from

[1]Hospitals also reported about $40 million (2 percent of total malpractice losses) in malpractice losses paid on behalf of patients covered by the Maternal and Child Health Services program, which is authorized by Title V of the Social Security Act.

$41 million in 1986 to about $101 million in 1990—an average annual increase of 20 percent. Malpractice losses for Medicare patients increased at a much slower rate, rising from $38 million in 1986 to $55 million in 1990—or an average annual increase of 8 percent. Malpractice losses for other patients increased about $130 million, from $283 million in 1986 to $413 million in 1990, or an average annual increase of about 8 percent. Malpractice losses for the 5-year period are shown in figure II.2.

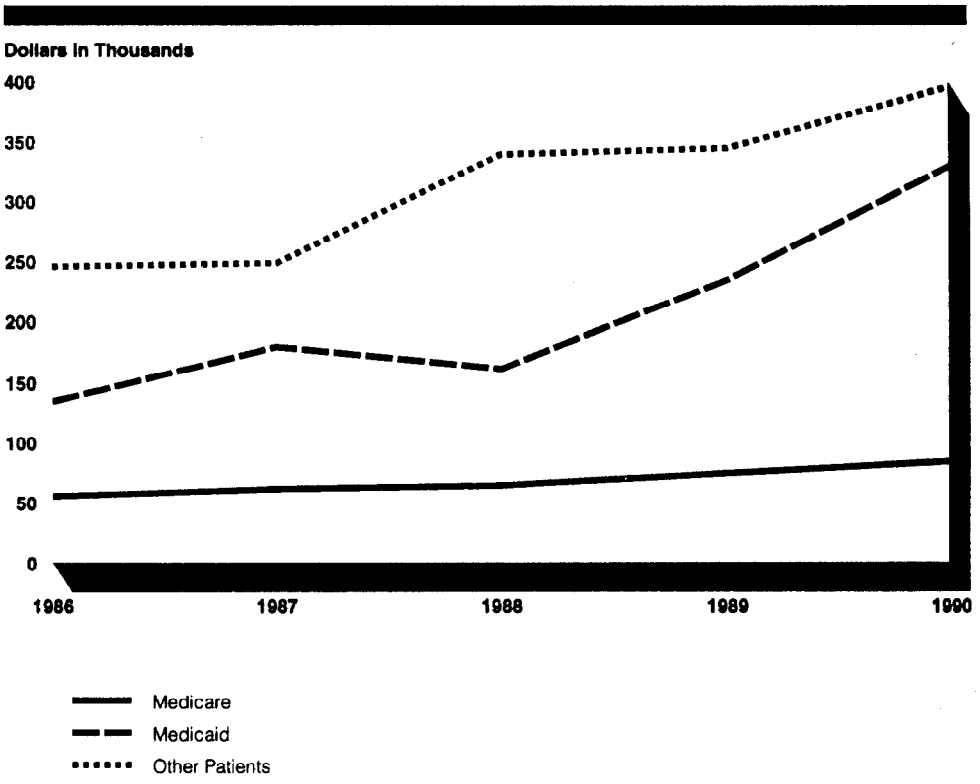
Figure II.2: Hospital Malpractice Losses by Type of Insurer, 1986 to 1990



Medicaid losses represented about 17.5 percent of total hospital malpractice losses in 1990, an increase of 6.7 percentage points from 1986. Malpractice awards for Medicaid patients increased from an average of $134,000 for hospitals with malpractice losses in 1986 to $330,000 in 1990. During the 5-year period, awards for Medicare patients remained at about 10 percent of total hospital losses, but the average malpractice awards for Medicare patients increased from an average of about $55,000 for hospitals with losses to $84,000. Malpractice awards for patients with other health

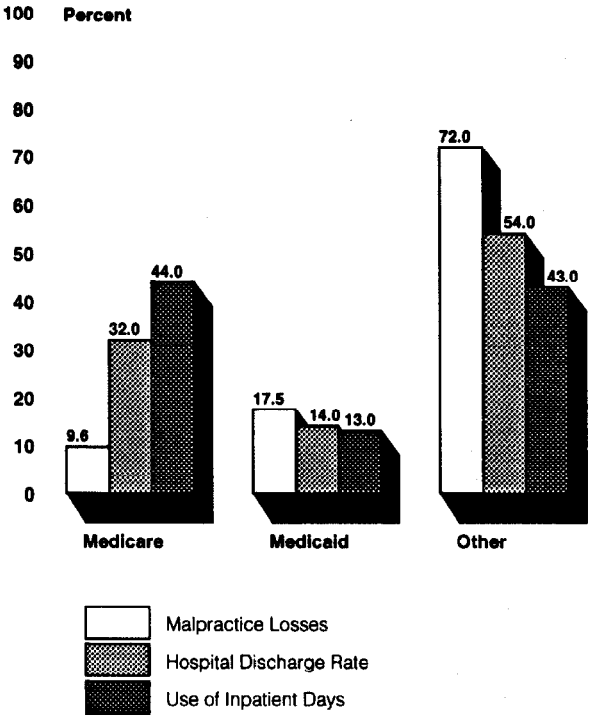
insurance coverage accounted for about 74 percent of all losses and increased from an average of $245,000 for hospitals with losses in 1986 to $396,000 in 1990. Figure II.3 shows the average hospital malpractice losses paid to Medicare, Medicaid, and other patients during the 5-year period.

Figure II.3: Average Hospital Malpractice Losses, 1986 to 1990



Comparing Medicare and Medicaid patients' malpractice awards to their use of hospital services shows striking differences. For example, Medicare patients are high users of hospital services, yet they account for a disproportionately small share of hospital malpractice losses. In 1990, malpractice awards paid for Medicare patients represented 9.6 percent of total hospital losses, yet Medicare patients accounted for 32 percent of all hospital discharges and 44 percent of inpatient days. As shown in figure II.4, the situation is quite different for Medicaid patients and patients with other insurance. Their percentage of malpractice losses exceeds their use of hospital services.

Figure II.4: Comparison of Malpractice Losses to Hospital Discharges and Use of Inpatient Days, 1990



Scope and Methodology

We reviewed studies done during the past two decades that provided information on the incidence of medically caused injuries, patients' tendency to file malpractice claims, the characteristics of malpractice claims, and the outcomes of malpractice litigation. By reviewing studies from an extended period, we were able to determine if the various factors associated with malpractice cases changed significantly. Some of these studies relied on data that were limited to the outcomes of malpractice litigation in a particular state. Our study of claims closed in 1984 and an earlier one by NAIC, however, were national in scope.

We obtained data from Medicare's Hospital Cost Report Information System (HCRIS) for about 6,300 hospitals. This is Medicare's national database for hospital costs and includes malpractice losses paid for all hospital patients, including those covered under the Medicare, Medicaid, and Maternal and Child Health Services programs. Although malpractice losses are summed for each hospital for the current year plus the prior 4 years, data on the corresponding number of malpractice claims are not included in HCRIS.

While HCRIS maintains data on hospital malpractice losses paid on behalf of Medicare, Medicaid, and other patients, similar data are unavailable for malpractice losses paid on behalf of physicians. Medical malpractice insurers are required to report payments made on behalf of physicians to the National Practitioner Data Bank, but information on the patient's health insurance coverage is not reported.

We analyzed HCRIS data on hospital malpractice losses for the five cost report periods beginning October 1, 1985, and ending September 30, 1990. In performing this review, we used other HCRIS information—such as patient discharges and inpatient bed-days. We performed our work between April and December 1992 in accordance with generally accepted government auditing standards.

Major Contributors to This Report

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Related GAO Products

Medical Malpractice: Experience With Efforts to Address Problems (GAO/T-HRD-93-24, May 20, 1993).

Health Information Systems: National Practitioner Data Bank Continues to Experience Problems (GAO/IMTEC-93-1, Jan. 29, 1993).

Practitioner Data Bank: Information on Small Medical Malpractice Payments (GAO/IMTEC-92-56, July 7, 1992).

Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992).

Medical Malpractice: Data on Claims Needed to Evaluate Health Centers' Insurance Alternatives (GAO/HRD-91-98, May 2, 1991).

Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990).

Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 22, 1987).

Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986).

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